



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

STAR ANESTHESIA PA  
45 NE LOOP 410 STE 900  
SAN ANTONIO TX 78216

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

CHUBB INDEMNITY CO

#### **Carrier's Austin Representative Box**

Box Number 17

#### **MFDR Tracking Number**

M4-11-1734-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "When the following CPT codes are reported with an anesthesia code, it is assumed that these services are being reported as part of the anesthesia service and so will not be paid in addition to the anesthesia code. ...many of these procedures...are not performed in the course of and as part of the anesthesia...these codes will be separately paid only if modifier -59 is appended..."

**Amount in Dispute:** \$103.91

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** A copy of the fee dispute was placed in the carrier box on February 14, 2011. A response was not submitted to the Division.

**Response Submitted by:** NA

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 1, 2010	64415-59	\$103.91	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets forth the medical fee guideline for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:  
Explanation of benefits dated October 25, 2010

- R77 – CCI; standard preparation/monitoring services
- 97 – charge included in another charge or service

Explanation of benefits dated December 9, 2010

- 168 – no additional allowance recommended
- 193 – original payment decision maintained
- B12 – Services not documented

### **Issues**

1. Does documentation support modifier -59 and are the respondent's denial reasons supported?
2. Is the requestor entitled to reimbursement?

### **Findings**

1. Division rule at 28 TAC §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

Division rule at 28 TAC §134.203(b) (1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The requestor billed CPT codes 64415-59 and 01630-AA. CPT 01630 is defined as "anesthesia for open or surgical arthroscopic procedures" and CPT 64415 is defined as "nerve block injection brachial plexus, single." The respondent denied reimbursement for CPT code 64415-59 with denial reasons "R77- CCI; standard preparation/monitoring services; 97 - charge included in another charge or service; and B12 - Services not documented."

Per NCCI edits, "procedure code 01630 and component procedure 64415 are unbundled. The Standard Policy Statement reads, 'Standard preparation/monitoring services.' The use of an appropriate modifier may be used." The requestor appended Modifier -59 to CPT 64415.

2. Modifier -59 is defined as "used to "identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

The documentation in this dispute is reviewed. The documentation does not support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury; therefore, the use of modifier 59 is not supported. The respondent's denial reasons are supported.

The requestor is therefore, not entitled to recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is not entitled to reimbursement for the services involved in this dispute.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
MAY , 2012  
Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**